BCBSVT Proposed Amendments to Governor's Proposed
FY 2017 Budget Bill Section E.307.6
February 18, 2016

Sec. E.306.7 33 V.S.A. § 1908 is amended to read:

§ 1908. MEDICAID; PAYER OF LAST RESORT; RELEASE OF INFORMATION

(a) Any clause in an insurance contract, plan or agreement which limits or excludes payments to a recipient is void.

(b) Medicaid shall be the payer of last resort to any insurer which contracts to pay health care costs for a recipient.

(c) Every applicant for or recipient of Medicaid under this subchapter is deemed to have authorized all third parties to release to the agency all information needed by the agency to secure or enforce its rights under this subchapter. The agency shall inform an applicant or recipient of the provisions of this subsection at the time of application for Medicaid benefits.

(d) ~~At the agency's request, an insurer shall provide the agency with the information necessary to determine whether an applicant or recipient of Medicaid under this subchapter is or was covered by the insurer and the nature of the coverage, including the member, subscriber, or policyholder information necessary to determine third party liability and other information required under 18 V.S.A. § 9410(h). The agency may require the insurer to provide the information electronically.~~ **~~On or after November 1, 2015, any~~ An** insurer shall accept the Agency's right of recovery and the assignment of rights and shall not charge the Agency or any of its authorized agents fees for the processing of claims or eligibility requests **~~as required by 18 V.S.A. § 9410(h)~~**. **~~Data files requested by or provided to the Agency shall provide the Agency with eligibility and coverage information that will enable the Agency to determine the existence of third party coverage for Medicaid recipients and the necessary information to determine during what period Medicaid recipients may be or may have been covered by the health insurer and the nature of the coverage that is or was provided, including the name, address, and identifying number of the plan.~~**

(e)(1) **Upon request and notwithstanding the federal Health Insurance Portability and Accountability Act (HIPAA) or other applicable state or federal privacy laws, an ~~The~~** insurer shall transmit to the Agency, in a manner prescribed by the Centers for Medicare and Medicaid Services or as agreed between insurer and the Agency, an electronic file of all **of insurers'** identified subscribers or policyholders, **~~or~~ and** their dependents.**~~, for whom there is data corresponding to the information contained in this section.~~ Data files requested by or provided to the Agency shall provide the Agency with eligibility and coverage information that will enable the Agency to determine the existence of third party coverage for Medicaid recipients and the necessary information to determine during what period Medicaid recipients may be or may have been covered by the ~~health~~ insurer and the nature of the coverage that is or was provided~~, including the name, address, and identifying number of the plan~~.**

(2) An insurer shall comply with a request under the provisions of this subsection no later than sixty (60) days after the date of request by the Agency and shall only be required to provide the Agency with the information required by this section.

(3) The Agency shall request the data from an insurer once every month. **The Agency shall not request policyholder or subscriber enrollment data that precedes the date of the request by more than three years.**

~~**(f)(1) Each insurer shall maintain a file system containing the name, address, group policy number, coverage type, social security number, and date of birth of each subscriber or policyholder, and each dependent of the subscriber or policyholder covered by the insurer, including policy effective and termination dates, claim submission address, and employer's mailing address.**~~

~~**(2) Data files requested by or provided to the Agency shall provide the Agency with eligibility and coverage information that will enable the Agency to determine the existence of third party coverage for Medicaid recipients and the necessary information to determine during what period Medicaid recipients may be or may have been covered by the health insurer and the nature of the coverage that is or was provided, including the name, address, and identifying number of the plan.**~~ **(4)The Agency shall use the data collected pursuant to this section solely for the purposes of determining whether a Medicaid recipient also has coverage with the insurer providing the data.**

(5) The Agency shall ensure that all data collected and maintained pursuant to this section is collected and stored securely and that such data is stored no longer than required to achieve the purpose of determining whether Medicaid benefits can be coordinated with the insurer, or as otherwise required by law. Insurers shall not be liable for any security incidents caused by the Agency in the collection or maintenance of the data collected.

(f) ~~**(g)**~~ The Agency shall promulgate rules governing the exchange of information under this section. Such rules shall be consistent with all laws relating to the confidentiality or privacy of personal information or medical records including, but not limited to, provisions under the federal Health Insurance Portability and Accountability Act (HIPAA).

~~**(e)**~~ **(g)** From funds recovered pursuant to this subchapter, the federal government shall be paid a portion equal to the proportionate share originally provided by the federal government to pay for medical assistance to a recipient or minor.

EXPLANATION: DVHA needs private insurer data files in a Medicaid format that CMS now uses to allow DVHA to determine whether members have private insurance that should pay for medical claims before DVHA pays claims. Further, federal law requires that the state shall provide assurances to the Secretary that it has in effect laws requiring health insurers to provide